State of California Department of Consumer Affairs

BOARD OF REGISTERED NURSING
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VERIFICATION OF CLINICAL COMPETENCY AS A NURSE PRACTITIONER METHOD 3 - EQUIVALENCY

Verification by a **nurse practitioner AND a physician** of the applicant's clinical competency in the delivery of primary health care is one of the requirements which must be met in order to qualify to use the title "Nurse Practitioner" in California.

PRIMARY HEALTH CARE is defined as that care which occurs when a consumer makes contact with a health care provider who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease (California Code of Regulations Section 1480(b)).

CLINICALLY COMPETENT means that one possesses and exercises that degree of learning, skill, care and experience ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice. The clinical experience must be such that the nurse received intensive experience in performing the diagnostic and treatment procedures essential to the provision of primary health care (California Code of Regulations Section 1480(c)).

The verifying nurse practitioner and physician **MUST** meet the following requirements:

1. **Current, clear and active licensure to practice.**
2. **Clinical competency in the provision of primary health care.**
3. **Direct observations of clinical practice.**

A. TO BE COMPLETED BY APPLICANT: Please print or type.

Name: (Last) (First) (Middle)	California RN License Number:
Social Security Number (Mandatory):	Date of Birth: (Month) (Day) (Year)
Signature of Applicant:_____	Date:_____

B. TO BE COMPLETED BY EVALUATOR (Nurse Practitioner/Physician): Please complete this form and return to the Board of Registered Nursing.

Name: (Last) (First) (Middle)		Social Security Number:
Address: (Number & Street) (City) (State) (Zip Code)		
Profession: ☐ **Physician** ☐ **Nurse Practitioner**	License Number: Expiration Date: NP Certificate Number:	Dates Employed in Specialty Area: From: _____ To: _____ Professional Specialty:
Method(s) Utilized to Evaluate Applicant's Clinical Competency:		
Period of Clinical Evaluation: From: To:		Telephone Number: Home ( ) Work ( )
I certify under penalty of perjury that I have evaluated the above named applicant and verify that he/she is clinically competent in the appropriate discipline in clinical practice in the provision of primary health care. Signature of Evaluator:_____ Date:_____		